



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

November 8, 2013

Public Health & Emergency Preparedness Bulletin: # 2013:44 Reporting for the week ending 11/01/13 (MMWR Week #44)

CURRENT HOMELAND SECURITY THREAT LEVELS

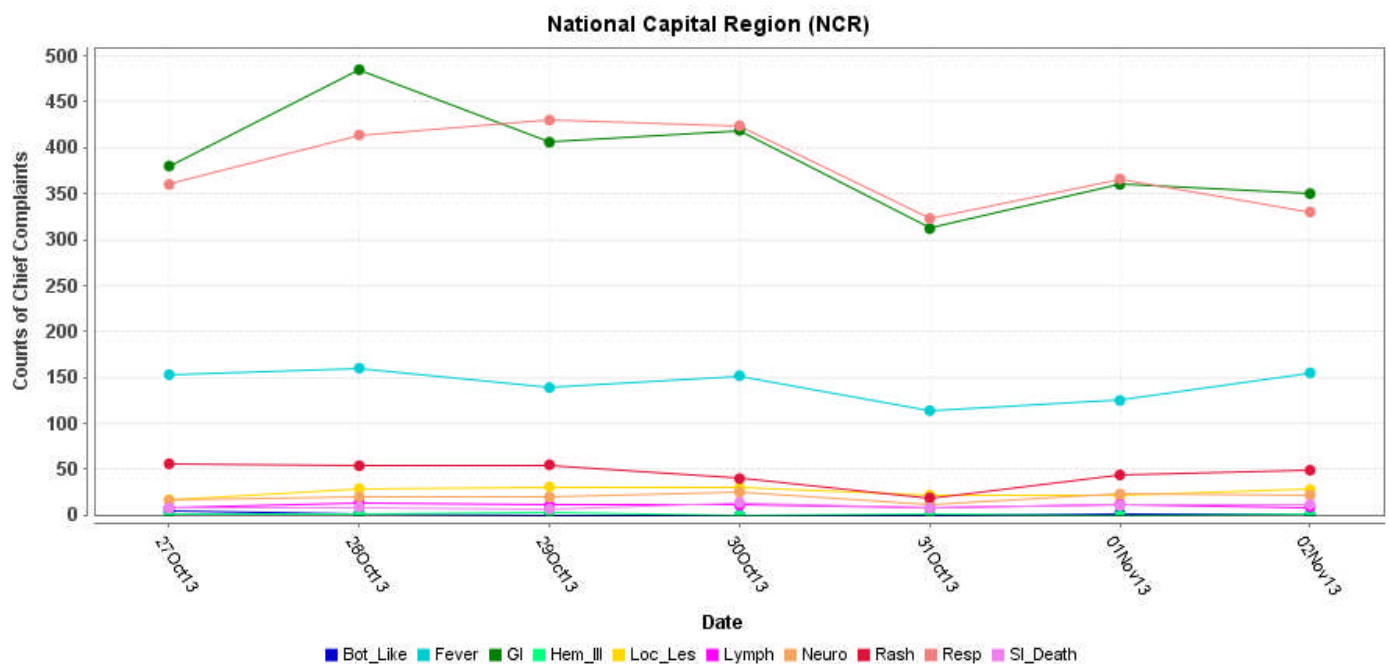
National: No Active Alerts
Maryland: Level Four (MEMA status)

SYNDROMIC SURVEILLANCE REPORTS

ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):

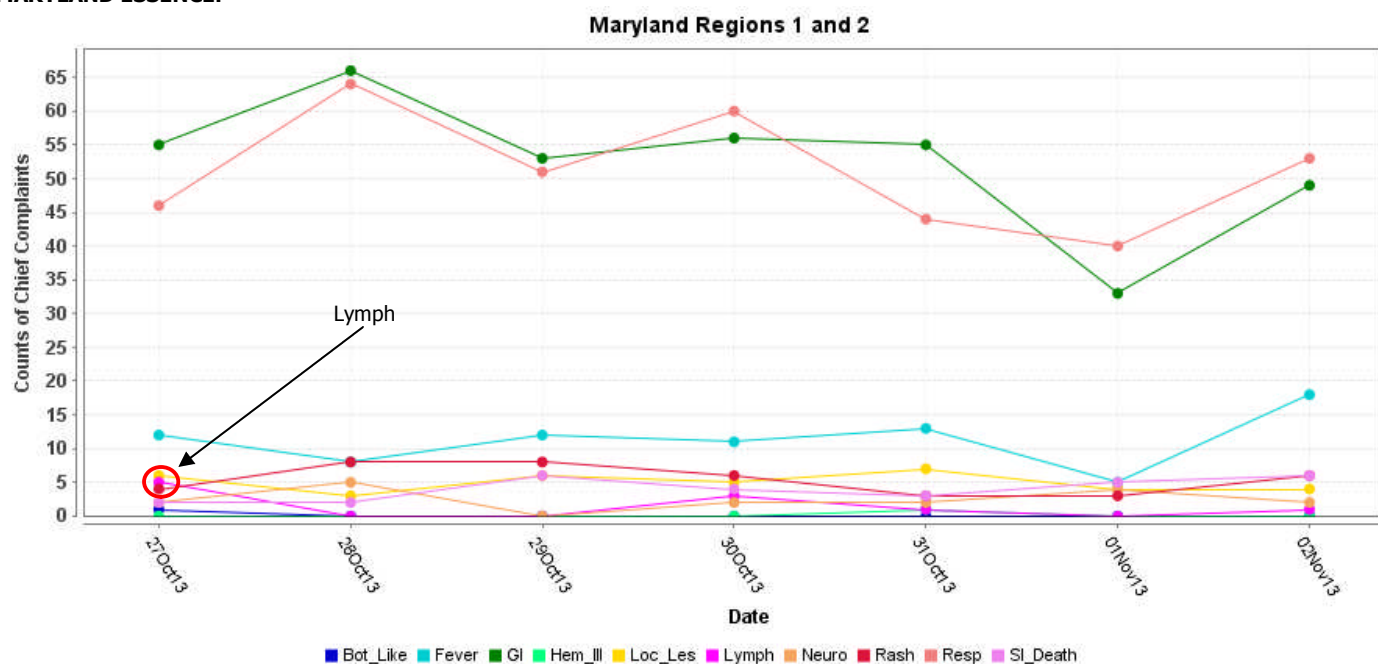
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.

Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

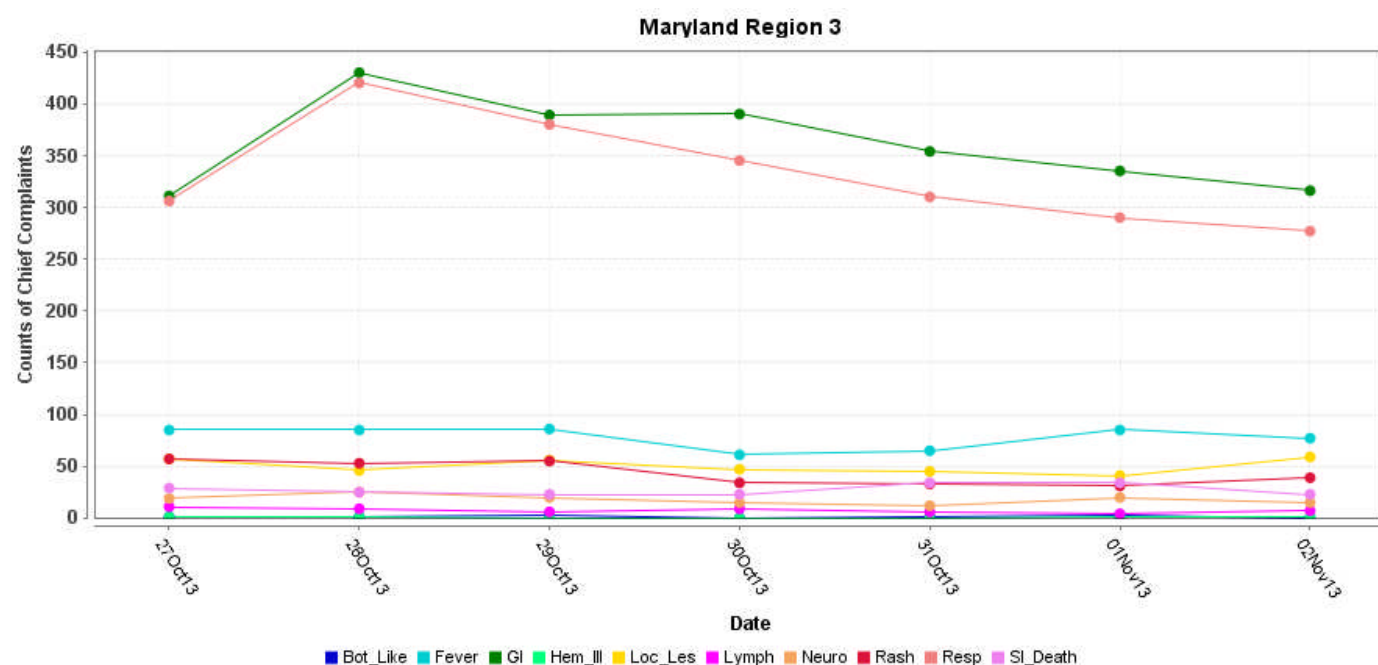


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

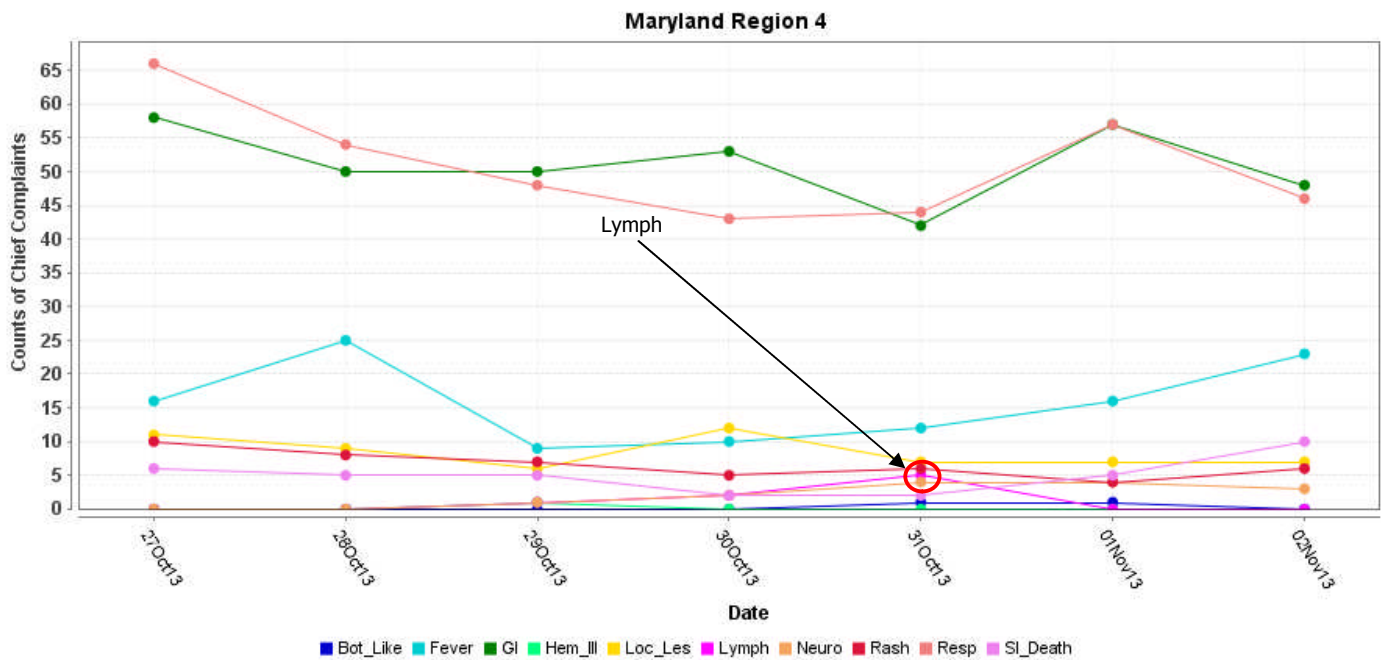
MARYLAND ESSENCE:



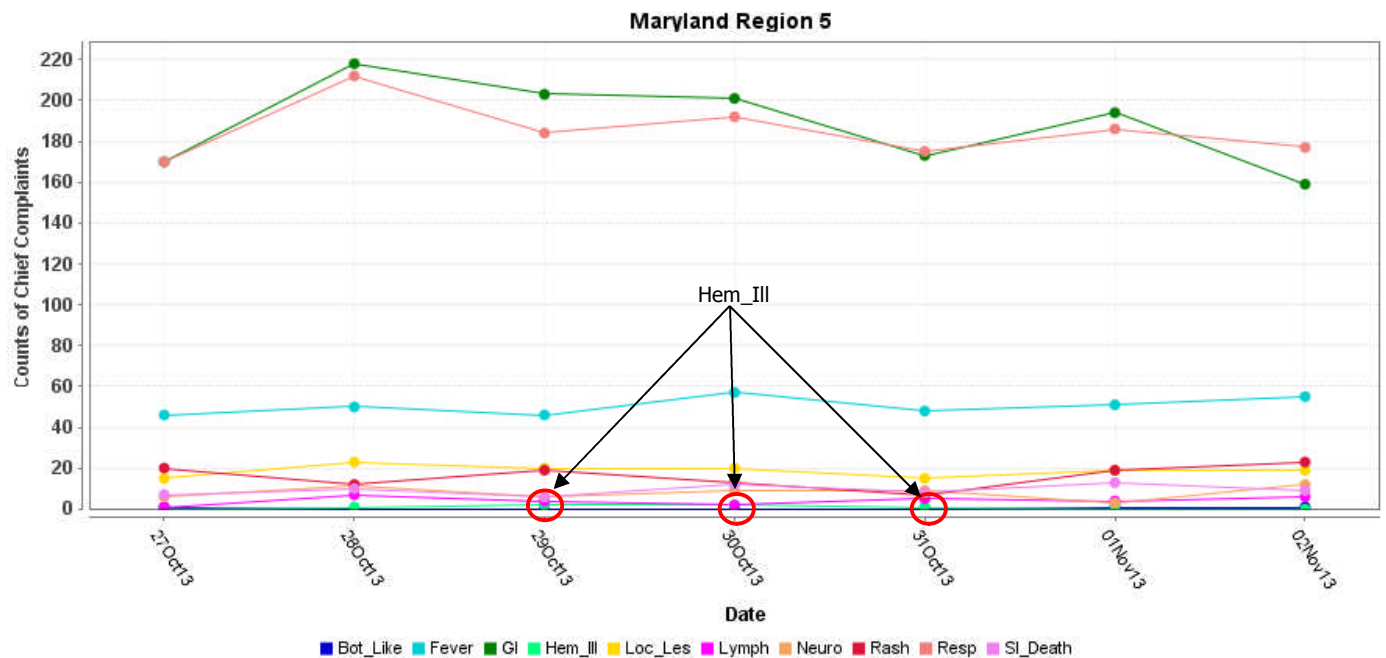
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE

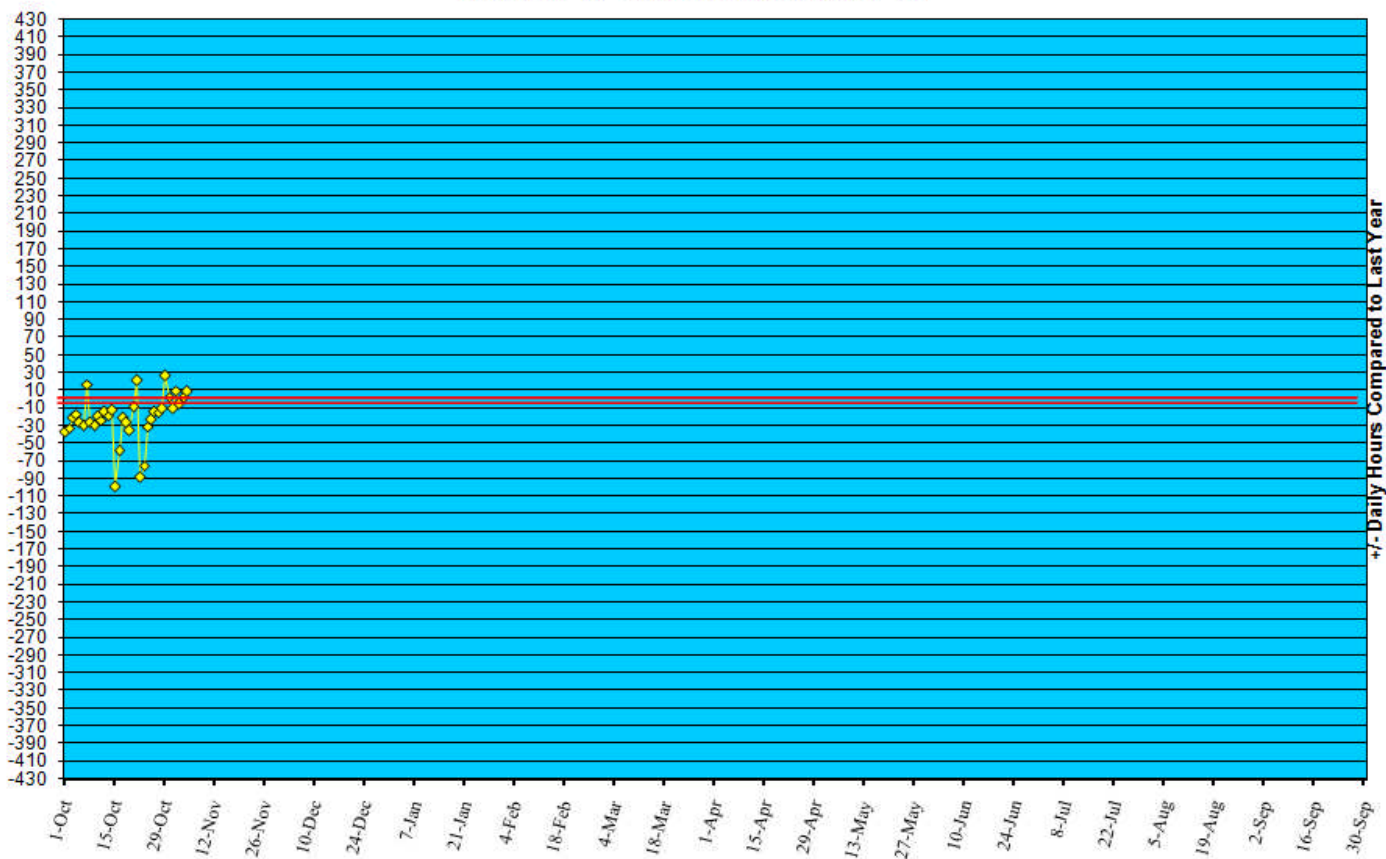


* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/13.

Statewide Yellow Alert Comparison Daily Historical Deviations October 1, '13 to November 2, '13



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in September 2013 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	Aseptic	Meningococcal
New cases (October 27 - November 2, 2013):	9	0
Prior week (October 20 - October 26, 2013):	23	0
Week#44, 2012 (October 29 – November 4, 2012):	14	0

3 outbreaks were reported to DHMH during MMWR Week 44 (October 27 - November 2, 2013)

1 Gastroenteritis Outbreak

1 outbreak of GASTROENTERITIS associated with a Farm

2 Respiratory Illness Outbreaks

1 outbreak of ILI/PNEUMONIA in a Nursing Home

1 outbreak of PNEUMONIA associated with a University

MARYLAND SEASONAL FLU STATUS

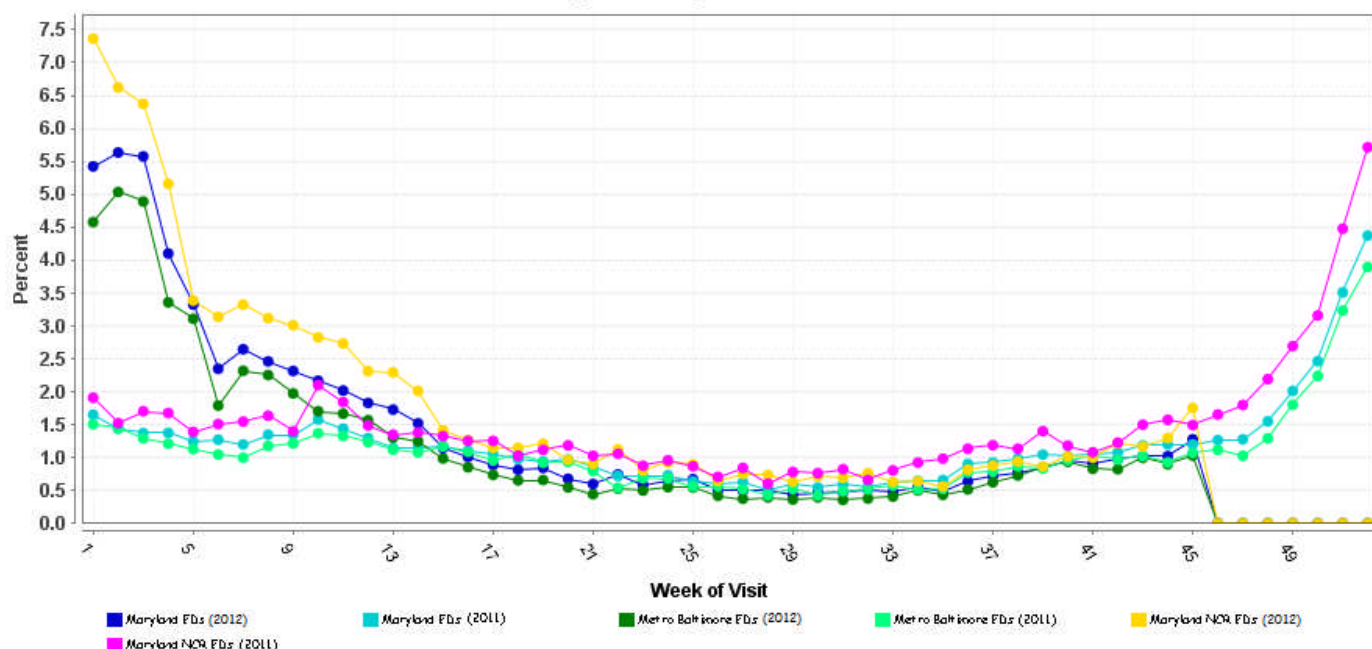
Seasonal Influenza reporting occurs October through May. Seasonal influenza activity for Week 44 was: Sporadic with Minimal Intensity

SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

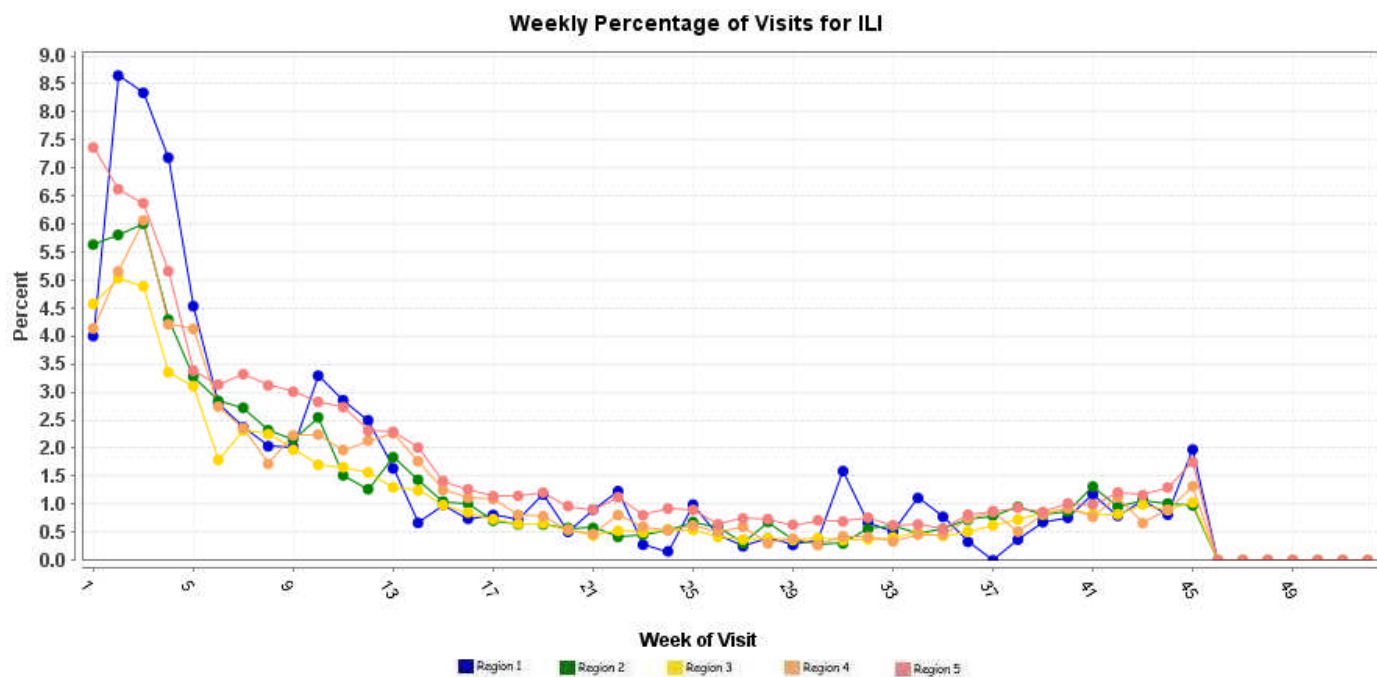
Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.

Weekly Percentage of Visits for ILI



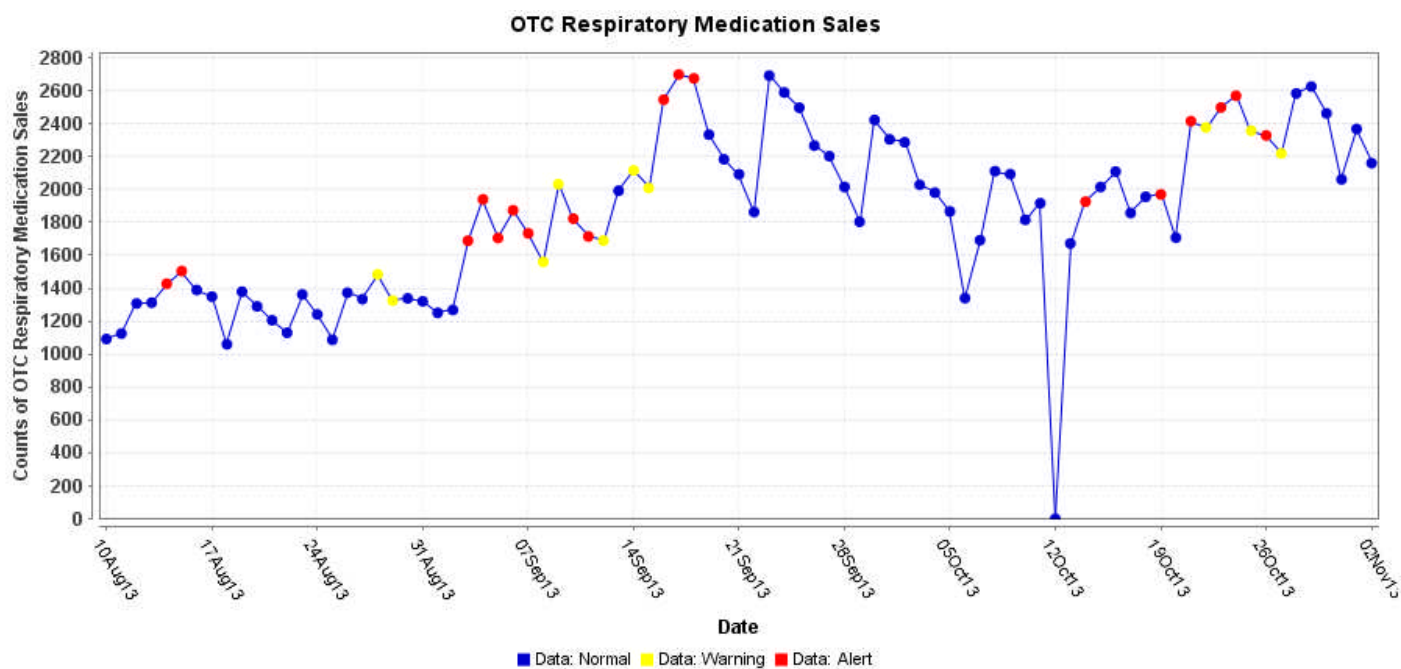
* Includes 2012 and 2013 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2013 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is ALERT. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

Influenza A (H7N9) is one of a subgroup of influenza viruses that normally circulate among birds. Until recently, this virus had not been seen in people. However, human infections have now been detected. As yet, there is limited information about the scope of the disease the virus causes and about the source of exposure. The disease is of concern because most patients have been severely ill. There is no indication thus far that it can be transmitted between people, but both animal-to-human and human-to-human routes of transmission are being actively investigated.

Alert phase: This is the phase when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the interpandemic phase may occur. As of October 8, 2013, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 641, of which 380 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 59%.

AVIAN INFLUENZA, HUMAN, H7N9 (CHINA): 28 October 2013, As of 28 Oct 2013: Rare, sporadic human infections with H7N9 avian influenza in China have been reported since the end of May [2013], following a surge of more than 130 cases with illness onset during the month of April [2013]. Most recently, China reported to the World Health Organization that 2 cases of H7N9 infection were detected there in October [2013]. Information about these cases was posted on the WHO website on 16 and 24 Oct 2013. These are the 1st cases of H7N9 reported since 11 Aug 2013 and bring the total number of cases reported to 137, including 45 deaths. These most recent cases are not unexpected and do not change the risk assessment for H7N9 at this time. As CDC indicated in May 2013, evidence suggests that there is a seasonal pattern to the circulation of avian influenza viruses, with activity declining in warmer seasons and increasing in cooler weather. This suggests that H7N9 avian influenza activity -- among birds and people -- might increase again in China as the weather turns cooler. It's likely that H7N9 cases will continue to be detected this winter in China; however, it's not possible to predict how many cases there will be. The most recent case of H7N9 in China reportedly occurred in a farmer who had contact with live poultry, suggesting that exposure to infected birds continues to be the main source of infection with this virus. There is no indication that the epidemiology of H7N9 has changed; China continues to report that there is no evidence of sustained human-to-human transmission with this virus. If more clusters of human-to-human spread or evidence of sustained human-to-human spread were detected, the risk assessment for H7N9 would change. In the meantime, H7N9 preparedness efforts by the US government have continued over the summer and CDC along with its global health partners are continuing to watch this situation closely.

AVIAN INFLUENZA, HUMAN, H5N1 (CAMBODIA): 31 October 2013, The Ministry of Health (MoH) of the Kingdom of Cambodia has announced a new human case of H5N1 avian influenza, according to a ministry press release Wednesday [30 Oct 2013]. According to the release (http://www.cdcmoh.gov.kh/PressRelease/43-Pressrelease_Eg.pdf): The case is a 6-year-old girl from Romdoul village, Romdoul commune, Phnom Preuk district, Battambang province confirmed positive for H5N1 avian influenza virus infection on 24 Oct 2013 by Institut Pasteur du Cambodge. The girl developed fever on 14 Oct 2013. On 15 Oct 2013, her parents sought treatment for her in the village. The girl's condition worsened and the girl was referred to the Jayavarman VII Hospital in Siem Reap. On 19 Oct 2013 she was admitted to the Jayavarman VII Hospital with fever, cough, abdominal pain, running nose, sore throat and dyspnea. Laboratory samples were taken on 22 Oct 2013 and Tamiflu administered on 24 Oct 2013. The girl is currently in a stable condition. This brings the total number of human H5N1 avian influenza cases to 22 this year [2013]. The investigation reveals that chickens and ducks have recently died in the girl's neighbor's house and in nearby villages. Health officials in Cambodia are identifying the child's close contacts as well as studying whether there are any epidemiologic links among the 22 patients infected this year. Animal health workers are investigating deaths in birds in the area. A statement from Minister of Health Dr. Mam Bunheng points out the special danger of H5N1 to children in that they commonly care for, feed, and clean the cages of domestic poultry and often treat them as pets. Parents are being urged through public health education campaigns to keep children away from sick or dead poultry, not allow them to play with chickens and ducks, and make sure they wash their hands with soap and water before eating and after contact with poultry.

NATIONAL DISEASE REPORTS*

E. COLI EHEC (TENNESSEE): 1 November 2013, Knox County (Tennessee) Health Department (KCHD) collected raw milk samples and a customer list from a Mascot farm Thursday, 31 Oct 2013, after 3 children were hospitalized with *E. coli* bacterial infections. All 3 children had consumed raw milk from McBee Dairy Farm on Strong Road. Specimens have been sent to the state Department of Health laboratory for testing, KCHD spokeswoman Katharine Killen said Friday, 1 Nov 2013. "No milk has been destroyed," Killen said, though a legal order prevents the farm from selling raw cow or goat milk while the investigation is active. Tennesseans can legally drink raw milk from cows they own. Several families own "shares" of cows on the dairy farm. The owner told a local television station she is advising customers not to drink any raw milk they might have until the investigation is complete. Children are more likely than adults to develop symptoms of *E. coli* which can include severe stomach cramps and stomach tenderness; nausea and vomiting; or watery or bloody diarrhea. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *non-suspect case

E. COLI EHEC (PENNSYLVANIA): 30 October 2013, In response to several cases of *E. coli*, the Allegheny County [Pennsylvania] Health Department is asking health care providers to test patients for the O157:H7 strain of *E. coli* if they have symptoms of the infection. In addition, anyone that develops bloody diarrhea is being urged to contact their health care provider. Several cases have occurred among employees and customers of The Porch restaurant in the Oakland neighborhood [of Pittsburgh]. A total of 5 persons have been diagnosed with *E. coli* infections since 1 Oct 2013. All of the individuals are recovering, although 4 of the 5 were hospitalized. *E. coli* are naturally occurring bacteria in the intestines of people and animals. Most of the strains are harmless, but [some such as] the O157:H7 strain can cause serious illness. Symptoms of the disease usually appear 3 to 4 days after exposure and may include severe stomach cramps, diarrhea (which is often bloody) and vomiting. Exposures typically result from the ingestion of contaminated foods. Persons who have developed bloody diarrhea or other symptoms should contact their health care provider and call the Health Department. "We're urging health care providers to test for *E. coli* to see if there are any additional cases linked to this outbreak so we can stop further transmission of the disease," said Health Director Dr. Karen Hacker. The Porch is fully cooperating and assisting with the Health Department investigation.

The restaurant has set up a toll-free hotline to answer any questions from the public. It has voluntarily closed for today [30 Oct 2013] and has been approved by the Health Department to re-open tomorrow [31 Oct 2013], after taking steps to ensure the safety of all its employees and customers. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *non-suspect case

LEGIONELLOSIS (PENNSYLVANIA): 30 October 2013, State health officials have asked doctors to take a closer look at anyone who developed pneumonia-like symptoms after visiting a South Whitehall Township [Lehigh County] outpatient facility after 6 cases of legionnaires' disease were linked to the site. Integrated Health Campus, at 240 and 250 Cetronia Road, houses a number of offices. In an advisory issued to health care facilities, the Pennsylvania Department of Health asked clinicians to be vigilant for signs of the disease, also called legionellosis, among patients who visited the campus in the 14 days before their illness. According to a statement from Integrated Health Campus, the investigation has focused on the 250 [Cetronia Road] building, specifically the decorative fountain in its lobby. The company hired Legionella Risk Management Inc. of Chalfont, Bucks County, to conduct an investigation and remediation of the campus water systems after being notified of the risk by the health department on 23 Oct 2013. Kenneth Szydlow, vice president of marketing and public relations for St Luke's University Health Network, said the 240 building -- which contains a number of St Luke's offices, including cancer treatment -- is no longer implicated in the alert. Dr Jeffrey Jahre said the health department had cleared the campus to continue business as usual. It would not have done so if it had believed staff and visitors were at risk. In an email, health department press secretary Aimee Tysarczyk said the department was limited in the information it could share because of restrictions under the Disease Prevention and Control Law regarding continuing investigations. Regarding the status of the 240 building, Tysarczyk wrote: "The entire campus is currently open; however, we're early in the investigation stages and therefore would not make immediate exclusions." She encouraged people with concerns to consult a doctor. "It's important for the public to know that *Legionella* is commonly found in various places in the environment and cases occur all the time throughout the state," Tysarczyk wrote. "Legionnaires' is a reportable disease in Pennsylvania, which means health care facilities, health care practitioners, and clinical laboratories are required to report it to the Department of Health within 24 hours and thereafter we will investigate those reports, which involves asking a series of questions, including where the individual has recently been."

Finding a location common to patients does not necessarily mean the location is the source of the disease, so the department has to expand its inquiry beyond that common denominator. Tysarczyk said IHC [Integrated Health Campus] had been cooperative and followed appropriate measures to assist with the investigation, and that the health department had followed traditional protocols by issuing an advisory -- one step below an alert, which indicates a more serious situation -- to health care professionals. The advisory urges vigilance about reporting potential cases so the department can follow up and investigate, Tysarczyk wrote. Integrated Health Campus's statement said the fountain in the lobby of the 250 building and a fountain outside the lobby were shut down and drained. The results of tests on the water are pending. The facility's drinking water system was also sanitized, though it was not considered a likely source of the infection. The health department conducted its own inspection, taking water samples Friday. "According to the Department of Health, in light of the rapid and extensive remediation, it is acceptable to continue business as usual at Integrated Health Campus," the IHC statement said. People get [legionnaires'] disease when they breathe in mist or vapor containing [*Legionella*] bacteria. Most people exposed to the bacteria don't get sick, and those who do typically recover with antibiotic treatment. The disease is not spread from person to person. Symptoms include cough, shortness of breath, and high fever, which typically begin 2 to 14 days after exposure. Older adults, smokers, and people with weakened immune systems are particularly susceptible. The disease is confirmed by a urine antigen test. Individuals without symptoms do not need to be tested. Most people with legionnaires' [disease] will have pneumonia, because the bacteria grow and thrive in the lungs [sic]. [All patients with legionnaires' disease will have pneumonia due to *Legionella* bacteria, because by definition legionnaires' disease is the acute pneumonic form of legionellosis.] Pneumonia is confirmed either by chest X-ray or physical exam.

INTERNATIONAL DISEASE REPORTS*

MERS-CoV (SAUDI ARABIA): 31 October 2013, WHO has been informed of an additional 4 laboratory-confirmed cases of infection with Middle East respiratory syndrome coronavirus (MERS-CoV). These include the 1st laboratory-confirmed case from Oman and 3 additional laboratory-confirmed cases from Saudi Arabia. The patient in Oman is a 68-year-old man from Al Dahkliya region who became ill on [26 Oct 2013] and was hospitalized on [28 Oct 2013]. Preliminary epidemiological investigations revealed that he did not recently travel outside the country. However, investigations are currently ongoing to determine what exposures might be responsible for his infection. Of the 3 patients including one death reported from the Eastern Region in Saudi Arabia, one is a woman and 2 are men. The 3 patients, one of whom is a health care worker, had underlying medical conditions. Their ages range from 49 to 83 years old. All 3 patients reported having no contact with animals prior to their illness, while one patient was reported to have been in contact with a previously laboratory-confirmed case. Globally, from September 2012 to date [31 Oct 2013], WHO has been informed of a total of 149 laboratory-confirmed cases of infection with MERS-CoV, including 63 deaths. Based on the current situation and available information, WHO encourages all Member States to continue their surveillance for severe acute respiratory infections (SARI) and to carefully review any unusual patterns. Health care providers are advised to maintain vigilance. Recent travellers returning from the Middle East who develop SARI should be tested for MERS-CoV as advised in the current surveillance recommendations. Patients diagnosed and reported to date have had respiratory disease as their primary illness. Diarrhoea is commonly reported among the patients, and severe complications include renal failure and acute respiratory distress syndrome (ARDS) with shock. It is possible that severely immunocompromised patients can present with atypical signs and symptoms. Health care facilities are reminded of the importance of systematic implementation of infection prevention and control (IPC). Health care facilities that provide care for patients suspected or confirmed with MERS-CoV infection should take appropriate measures to decrease the risk of transmission of the virus to other patients, health care workers and visitors. All Member States are reminded to promptly assess and notify WHO of any new case of infection with MERS-CoV, along with information about potential exposures that may have resulted in infection and a description of the clinical course. Investigation into the source of exposure should promptly be initiated to identify the mode of exposure, so that further transmission of the virus can be prevented. WHO does not advise special screening at points of entry with regard to this event, nor does it currently recommend the application of any travel or trade restrictions. WHO has convened an Emergency Committee under the International Health Regulations (IHR) to advise the Director-General on the status of the current situation. The Emergency Committee, which comprises international experts from all WHO Regions, unanimously advised that, with the information now available, and using a risk-assessment approach, the conditions for a Public Health Emergency of International Concern (PHEIC) have not at present been met. (Emerging Infectious Diseases are listed in Category C on the CDC List of Critical Biological Agents) *Non-suspect case

CHOLERA (NIGERIA): 31 October 2013, In the last couple of days, some states in Nigeria have come under the spell of cholera epidemic. And aside those still anguishing in hospitals from the attack, the death toll also gives cause for concern. Weekly Trust investigations show that Plateau, Sokoto, Zamfara and Lagos States have been hit by cholera epidemic. Zamfara recorded 1117 cases with official confirmation of 72 deaths in 2 weeks. Unofficial sources said the casualty figure is higher as the official statistics did not reflect those that died either at home or before reaching the hospitals. According to the Medical teams managing the cholera outbreak in the state, Gusau recorded the highest number of cholera cases, followed by Zurmi, Maradun and

Bakura local government areas. At the Shagari Primary Health Care Center, 90 fresh cases were recorded in a day, an official said. In Namu, a small village in Quan'Pan Local Government Area of Plateau State, with just one Primary Healthcare Clinic (PHC) and no decent source of drinking water, had to suddenly cater for an additional 6490 displaced people from Nasarawa State. Weekly Trust gathered that over 6000 internally displaced persons from the violence in Obi Local Government Area of Nasarawa State have relocated to Namu for refuge and are presently housed in a camp. Reports say the cholera outbreak started in the camp of the displaced persons, who eat, sleep and use the same latrines with the indigenes of Namu. It was observed in the Anguwan Yashi community, which hosts most of the displaced persons that over 50 people squeeze themselves in small compounds. Also, in some houses, about 20 people squat, sharing sleeping space every night in tiny rooms. Also, only wells serve as sources of drinking water, usually open and unhygienic. Based on the set up, cholera epidemic struck the displaced and indigenes, the young and the old, men and women in the community. Plateau State government admits the outbreak of cholera in the state, and claimed that only 9 people have been killed. But the community claims 30 people have so far died from the cholera outbreak. None could however dispute that over 100 people have been infected and treated from the outbreak. Health workers claimed that cholera was reported in the Namu village on 5 Oct 2013, but knowledge of the epidemic became public after the State Emergency Management Agency (SEMA) team from Nasarawa and Plateau States visited Namu last week. The District Head of the village, Alhaji Abubakar Sadiq claimed that mortality numbers have been downplayed, adding that most of those killed by the scourge were women nursing their children. Sadiq said "both indigenes of the village and the displaced have been affected because we now live together. And I can count over 10 of the indigenes who have died from this disease, including my brother's wife, my neighbor and her daughter." Despite claims by the community and officials in Plateau, the Nasarawa State government is denying that its population which is displaced in the neighbouring Plateau State is hit by cholera outbreak. Dr. Abdullahi Idris, Executive Secretary of Nasarawa State Emergency Management Agency (NASEMA), told Weekly Trust that the state Ministry of Health sent a consignment of medicals to Namu to treat the displaced persons there, but insisted that they are merely suffering from vomiting and diarrhea. He said the result of a detailed laboratory test is still being expected to confirm the disease, and added that the state government is not taking chances, and has taken far reaching steps to control vomiting and diarrhea, while also stepping up prevention of possible cholera outbreak. Similarly, cholera outbreak hit Tambuwal and Kebbe Local Government Areas in Sokoto State. Scores of people were killed and the community blamed poor source of water for the outbreak. The state government official statement on the matter pegged the death toll at 13 by last Thursday, 24 Oct 2013, and put the total number of victims in the 2 local government areas at 152. In Barkeji alone, a village located along Sokoto-Jega road in Tambuwal Local Government Area where the disease was said to have 1st surfaced, 31 cases were recorded between 10 and 21 Oct 2013; 5 persons were confirmed dead, 21 discharged and 2 were still on admission and positively responding to treatment. In Kebbe Local Government Area, which is less than 20 kilometers from Tambuwal, the disease resurfaced in Bakin Dutse, Tuna, 'Yar-Romo, Nabasa, Fakku and Bashi, all in riverine area. At least, out of 121 cases, 8 deaths were recorded. In the Lagos State cholera outbreak, which has hit 5 local government areas and has so far claimed the lives of at least 3 persons, a few others were reportedly discharged after treatment. Lagos State Commissioner for Health, Dr. Jide Idris, who made the disclosure in Alausa, Ikeja, pleaded with residents to report any case of cholera to the nearest health facility as well as maintain high level of hygiene. Idris said "although many of the cases had been treated and discharged in several health facilities, 3 had been confirmed dead. Most of the suspected cases were from Ajeromi, Apapa, Lagos Island, Oshodi, Isolo and Surulere Local Government Areas." (Water Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

National and International Disease Reports are retrieved from <http://www.promedmail.org/>.

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: <http://preparedness.dhmmh.maryland.gov/>

Maryland's Resident Influenza Tracking System: <http://dhmmh.maryland.gov/flusurvey>

NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail us. If you have information that is pertinent to this notification process, please send it to us to be included in the routine report.

Zachary Faigen, MSPH
Biosurveillance Epidemiologist
Office of Preparedness and Response
Maryland Department of Health & Mental Hygiene
300 W. Preston Street, Suite 202
Baltimore, MD 21201
Office: 410-767-6745
Fax: 410-333-5000
Email: Zachary.Faigen@maryland.gov

Anikah H. Salim, MPH, CPH
Biosurveillance Epidemiologist
Office of Preparedness and Response
Maryland Department of Health & Mental Hygiene
300 W. Preston Street, Suite 202
Baltimore, MD 21201
Office: 410-767-2074
Fax: 410-333-5000
Email: Anikah.Salim@maryland.gov

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents

Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	<p>ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media)</p> <p>SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus</p> <p>ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis</p> <p>ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain</p> <p>EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE <i>acute exacerbation</i> of chronic illnesses.)</p>	<p>Anthrax (inhalational)</p> <p>Tularemia</p> <p>Plague (pneumonic)</p>
Neurological	<p>ACUTE neurological infection of the central nervous system (CNS)</p> <p>SPECIFIC diagnosis of acute CNS infection such as pneumococcal meningitis, viral encephalitis</p> <p>ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephalitis NOS, encephalopathy NOS</p> <p>ACUTE non-specific symptoms of CNS infection such as meningismus, delirium</p> <p>EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's</p>	Not applicable
Rash	<p>ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs)</p> <p>SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox</p> <p>ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem</p> <p>EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheic dermatitis, rosacea</p> <p>EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema</p>	Smallpox
Specific Infection	<p>ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal)</p> <p>INCLUDES septicemia from known bacteria</p> <p>INCLUDES other febrile illnesses such as scarlet fever</p>	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents (continued from previous page)

Syndrome	Definition	Category A Condition
Fever	<p>ACUTE potentially febrile illness of origin not specified</p> <p>INCLUDES fever and septicemia not otherwise specified</p> <p>INCLUDES unspecified viral illness even though unknown if fever is present</p> <p>EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome</p>	Not applicable
Severe Illness or Death potentially due to infectious disease	<p>ACUTE onset of shock or coma from potentially infectious causes</p> <p>EXCLUDES shock from trauma</p> <p>INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births</p> <p>EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths</p>	Not applicable

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION**

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Web Site: www.dhmf.maryland.gov